STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	PLE CON	ISTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL: 04/30/	
			B. WING			04/30/	2013
NAME OF P	ROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE AIG ST		
BERKSH	IRE OF CASTLETO	ON			POLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG R000000	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCT)		DATE
1000000							
	This visit was f	for a State Residential /ey.	R00000	00			
	Survey dates : April 29 and 30, 2013						
	Facility numbe	r : 009894					
	Provider numb						
	AIM number : I	N/A					
	Survey team :						
	Michelle Hoste						
	Janet Stanton,						
	Gloria Bond, R	<sup>k</sup> N					
	Census bed ty	ne:					
	Residential: 1	•					
	Total: 135	00					
	101011.100						
	Census payor	type:					
	Other: 135	•					
	Total : 135						
	Sample : 11						
	There ( ) (	allo de la companya de la Co					
		idings are cited in					
	accordance Wi	th 410 IAC 16.2					
	Ouality Review	was completed by					
	•	RN on May 7, 2013.					
	Tallilly / licy I	11 011 May 1, 2010.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 1 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
				LDING		04/30/	/2013
			B. WIN		ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEDIKOLI	IDE OF OAOT! ETC				RAIG ST		
BERKSH	IRE OF CASTLETO	JN .		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000051	410 IAC 16.2-5-1	.2(u)					
	Residents' Rights	- Offense					
	(u) Residents hav	e the right to be free from					
	any physical or chemical restraints imposed						
		scipline or convenience					
	·	to treat the resident ' s					
	medical symptom						
	Based on observation, interview and		R00	00051	Berkshire of Castleton addend	um	05/29/2013
		the facility failed to			responses for annual survey:		
	ensure that 5 o	f 5 residents reviewed,			4-30-13		
	who were living	on the locked Terrace			Addendum request R 51: Ca	an	
	unit, were not r	estrained by being			all residents residing on the	<b></b>	
	moved to that unit. This deficiency had the potential to impact 21 of 21				Terrace Unit utilize the keypad		
					with the appropriate code to ex		
	residents living	•			the unit? Response: Becaus	е	
	•				not all residents living on the		
	(Residents #6,	#7, #10, #16, and #21)			Terrace area are able to manage		
					a keypad for exit, we have		
	Findings includ	e:			decided to unlock the door,		
					allowing access to the remaind	aer	
	In an interview	during the entrance			of the community.		
	conference on	4/29/13 at 9:45 A.M.,			Addendum to R51: How were	all	
	the Administrat	or indicated the			the residents assessed to ensi	-	
	Terrace unit wa	as a locked unit,			they could exit the unit at will be		
		e be entered into a key			the use of the keypad?	,	
	• •	-			Response: The Personal Serv	/ice	
	•	nces and exits. She			Assessment will be utilized for	all	
		nit was not designated			residents in the community, as	s it	
	as an Alzheime	er's/Special Dementia			addresses all physical and		
	Care unit.				cognitive issues related to		
					resident care and services.		
	In an interview	during the initial			Because the unit will no longer locked, no additional assessm		
		on 4/29/13 at 10:00			will be required.	CIIL	
		h and Wellness			wiii be required.		
	Director indicat				Addendum to R51: For reside	nts	
					residing on the Terrace unit wh		
	residents residing on the Terrace unit				cannot utilize the keypad, have		
		irs for mobility. The			they been assessed for a lock		
	other 14 reside	nts were ambulatory.			unit with appropriate physician		
I			1		Ī		1

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 2 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED
			B. WING	1110		04/30/2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u></u>
NAME OF F	PROVIDER OR SUPPLIEF	₹			RAIG ST	
DEDICH	IRE OF CASTLETO	ON.			APOLIS, IN 46250	
DERNON	IRE OF CASTLETO	JIN		INDIAN	APOLIS, IN 40250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	She indicated 3	3 of the residents could			orders, assessment and service	ce
	be interviewed	, but each had some			plans to reflect this?	
	level of forgetfulness or confusion.				Response: No additional	
	l level of lorgeth	diffess of confusion.			assessment for a locked unit v	vill
					be required, because the	
		on 4/30/13 at 10:15			residents now have access to	
	A.M., the Admi	nistrator indicated			other areas of the community	
	residents were	moved to the Terrace			without having to utilize a code	
	unit when their	level of needs			Physician orders will be obtain	
		a change in condition			for transferring residents to the	
					Terrace, as a higher level of coneeds can be met in the small	
		ner level of assistance			environment.	ei ei
	by staff. She indicated the "biggest"				environment.	
	change was usually one of developing				Addendum to R51: How often	ı will
	or increasing ir	ncontinence or			the residents on The Terrace	
	transferring (in	and out of bed, in and			be evaluated on the ability to	
	out of a wheeld	chair). The Terrace			utilize the keypad and exit the	unit
		er staffing ratio to be			at will?	
		this assistance.			Response: No additional	
	l apie io provide	tills assistance.			assessment for a locked unit v	vill
	l				be required, because the	
		v, the Administrator			residents now have access to	
	indicated there	was no reason the			other areas of the community	
	unit had to be I	locked"It's always			without having to utilize a code	€.
	been locked."	As far as she was			The following is the Plan of	
		had never been			Correction for Berkshire of	
		Alzheimer's/Special			Castleton in regards to the Statement of Deficiencies for t	the
	•	•			annual survey completed on	.116
	Dementia Care	turiit.			4-30-13. This Plan of Correction	on
					is not to be construed as an	
		on 4/30/13 at 11:15			admission of or agreement wit	th
	A.M., the Admi	nistrator indicated she			the findings and conclusions in	
	hadn't really th	ought about the unit			the Statement of Deficiencies,	
	1	pecause it had been			any related sanction or fine.	
	•				Rather, it is submitted as	
	that way since she was first employed				confirmation of our ongoing	
	at the facility.				efforts to comply with statutory	
					and regulatory requirements. I	
		cords for 5 of the			this document, we have outline	
	residents living	on the unit indicated			specific actions in response to	1

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 3 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
				LDING		04/30/	2013
			B. WIN		ADDRESS OVEN STATE JID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					RAIG ST		
BERKSH	IRE OF CASTLETO	ON		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the following:				identified issues. We have not		
					provided a detailed response t	0	
	Λ The clinical	record for Pesident #6			each allegation or finding, nor		
	A. The clinical record for Resident #6 was reviewed on 4/29/13 at 10:50				have we identified mitigating		
					factors. We remain committed		
		dent was originally			the delivery of quality health ca	are	
	admitted to the	e "independent" area of			services and will continue to		
	the facility on 4	l/19/09. Diagnoses			make changes and		
	included, but w	vere not limited to,			improvements to satisfy that objective. R_051 Resident		
	· ·	kinson's disease,			RightsWhat corrective action(s	:)	
	l '	d benign prostatic			will be accomplished for those	,	
	I .	nlarged prostate).			residents found to have been		
	Гиуреннориу (е Г	marged prostate).			affected by the alleged deficie	nt	
					practice? Residents #6, #7,		
		documentation			#10, #16, and #21: The Terra	ce	
	indicated the re	esident had been in his			area of the community now ha	S	
	room on the Te	errace unit since at			the code posted at the door to		
	least 4/18/12.				allow entrance and egress from	n	
					the Terrace area into the		
	A physician's c	order for the resident's			remainder of the community, to		
		locked unit was not			allow intra-community movement		
		locked drift was not			at the discretion of the residen Residents #6, #7, #10, #16		
	found.				#21: Personal Service	ariu	
					Assessments and Personal		
	1	13, the resident was			Service Plans have been upda	ited	
	sent to an acut	te care hospital			by a licensed nurse to include		
	emergency roo	om following a mental			documentation and data		
	status change	and a fall. He was			correction information regardir	ng	
	transferred to a	another facility to			the need for these individuals		
		itation, and returned on			reside on the Terrace, based of		
		•			the care needs identified on th		
	3/23/13. He subsequently sustained 4 falls without injury. An alarm and other interventions were implemented.				assessment. Residents #6, #	7,	
					#10, #16, and #21: Physician orders were obtained to reflect	+	
					their appropriateness to reside		
					the Terrace area of the	· 5	
					community. How will the facilit	V	
	A Service Plan	, dated 3/29/13,			_	-	
	indicated the re	esident required the			potential to be affected by the		
					same alleged deficient practice	Э	
	A Service Plan, dated 3/29/13, indicated the resident required the physical assistance of staff for				identify other residents with the potential to be affected by the	9	

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 4 of 30

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250  SLAMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL RIGIDATION)  BASHING, dressing, transferring, and toileting. The resident was identified as incontinent of both bowel and bladder. He required the use of a wheelchair, and the assistance of 2 staff for transfers.  There was no indication on the Service Plan why the resident was required to live on a locked unit.  B. The clinical record for Resident #7 was reviewed on 4/30/13 at 8:30 A.M. The resident and a family member were both admitted to the same apartment in the "independent" area of the building on 2/28/13. Diagnoses included, but were not limited to, depression and senile dementiaAlzheimer's type.  A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  Between 3/11 and 3/22/13, the	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER  BERKSHIRE OF CASTLETON  BUSINGARY STATEMENT OF DEFICIENCIES  (ACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Dathing, dressing, transferring, and toileting. The resident was identified as incontinent of both bowel and bladder. He required the use of a wheelchair, and the assistance of 2 staff for transfers.  There was no indication on the Service Plan why the resident was required to live on a locked unit.  B. The clinical record for Resident #7 was reviewed on 4/30/13 at 8:30 A.M. The resident admitted to the same apartment in the "independent" area of the building on 2/28/13. Diagnoses included, but were not limited to, depression and senile dementia—Alzheimer's type.  A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  PREFIX PROVIDERS ACTIVESTATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250  INDIANAPOLIS, IN 46250  DATE  DEPRETIX PROVIDERS PLAN OF CORRECTION (NS)  COMPLETION DATE  And what corrective action will be taken? Other residents with the potential to be affected by the alleged deficient practice currently reside on the Terrace. The Terrace area of the community, is, by plan, an area where the staffing ratio is higher than the rest of the AL community, and where there is a designated licensed nurse present to provide med administration communicate with the physician on behalf of the resident certified nursing assistants present to supervise and assist with ADL care and dining needs, as well as Optimum Life Programming available, in order to better meet the physical and cognitive needs of residents who may not function as highly in the larger population or this AL community. This 23 apartment area is available to allow a higher level of success to residents who desire to move in or remain in the assisted living community of their choice and preference, and is not designed to restrain or restrict their ability to	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD	ING	00	COMPL	ETED
STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250  IN							04/30/	2013
BERKSHIRE OF CASTLETON  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Dathing, dressing, transferring, and toileting. The resident was identified as incontinent of both bowel and bladder. He required the use of a wheelchair, and the assistance of 2 staff for transfers.  There was no indication on the Service Plan why the resident was required to live on a locked unit.  B. The clinical record for Resident #7 was reviewed on 4/30/13 at 8:30 A.M. The resident and a family member were both admitted to the same apartment in the "independent" area of the building on 2/28/13. Diagnoses included, but were not limited to, depression and senile dementiaAlzheimer's type.  A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  BERKSHIRE OF CASTLETON  ID PROFIDE COMPLETION  PREFIX TAG  BRECHLATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX TAG					STREET A	DDRESS, CITY, STATE, ZIP CODE		
INDIANAPOLIS, IN 46250   INDIANAPOLIS, IN 46	NAME OF F	PROVIDER OR SUPPLIEF	t .					
Description of the process of the community is, by plan, an area where the staffing ratio is higher than the resident and a family member were both admitted to the same apartment in the "independent" area of the building on 2/28/13. Diagnoses included, but were not limited to, depression and senile dementia—Alzheimer's type.  PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION)  TAG REGILATORY OR LSC IDENTIFYING INFORMATION  TAG REGILATORY OR LSC IDENTIFY AND WILL BETCH	BERKSH	IIRE OF CASTLETO	ON					
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There was no indication on the Service Plan why the resident was required to live on a locked unit.  B. The clinical record for Resident #7 was reviewed on 4/30/13 at 8:30 A.M. The resident and a family member were both admitted to the same apartment in the "independent" area of the building on 2/28/13. Diagnoses included, but were not limited to, depression and senile dementia-Alzheimer's type.  A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  Community, and where there is a designated licensed nurse present to provide med administration communicate with the physician on behalf of the resident, certified nursing assistants present to supervise and assist with ADL care and dining needs, as well as Optimum Life Programming available, in order to better meet the physical and cognitive needs of residents who may not function as highly in the larger population of this AL community. This 23 apartment area is available to allow a higher level of success to residents who desire to move-in or remain in the assisted living community of their choice and preference, and is not designed to restrain or restrict their ability to				1		-	er	
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depression and senile dementiaAlzheimer's type.  A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  Between 3/11 and 3/22/13, the		included, but w	ere not limited to,					
A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  Between 3/11 and 3/22/13, the		depression and	d senile dementia-			<del>_</del>		
A Nurse's Note, dated 3/9/13, indicated the resident was alert and oriented to time, place, and person.  Between 3/11 and 3/22/13, the		-Alzheimer's ty	pe.			•	23	
indicated the resident was alert and oriented to time, place, and person.  Retween 3/11 and 3/22/13, the residents who desire to move-in or remain in the assisted living community of their choice and preference, and is not designed to restrain or restrict their ability to						-		
indicated the resident was alert and or remain in the assisted living community of their choice and preference, and is not designed to restrain or restrict their ability to		A Nurse's Note	e, dated 3/9/13.					
oriented to time, place, and person.  Community of their choice and preference, and is not designed to restrain or restrict their ability to				1				
Petween 3/11 and 3/22/13, the preference, and is not designed to restrain or restrict their ability to						_		
Between 3/11 and 3/22/13, the to restrain or restrict their ability to			-, p. 200, a. 12 poi 00				d	
Violt and narticinate in activities in		Retween 3/11	and 3/22/13, the			to restrain or restrict their abilit	y to	
I recident was found outside the			· ·			visit and participate in activities		
any other area of the community.		resident was found outside the					ity.	
		_						
street from the building, once in the licensed as an Assisted Living (Licensed Residential)			•			_		
parking lot, and office conting back in		parking lot, and once coming back in				,	otal	
the front door. The first 2 times, door		the front door. The first 2 times, door alarms had alerted the staff that someone had exited from the building. On 3/24/13, another family						
alarms had alerted the staff that AL apartments are on The								
rondoo,, and mare deposit, to								
member came and stayed in the individuals. · All residents who		member came	and stayed in the			individuals. · All residents wh	0	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			04/30/	2013
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			RAIG ST		
BERKSH	IRE OF CASTLETO	NC			APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	apartment.				live within the community pay		
					privately, and sign residency		
	In an interview on 4/30/13 at 10:00				agreements at the time of move-in, advising them of their	r	
	A.M., LPN #1 indicated the resident				rights and terms or residency,		
		ed to the locked unit on			well as charges involved in the		
	3/28/13.				personal care, if any is require		
					At no time is a decision ever		
	A physician's c	order for the move to			made to move or relocate any		
		was not found.			resident without proper assessment, consultation with	0	
		was not round.			physician, and the consent of		
	On $4/20$ and $4$	/30/13, the resident			legally responsible party, unles		
					the health or safety of the		
		to walk freely around			resident is at risk. · Please no	ote:	
		own. On 4/29/13 at			There is no area of this		
		resident was observed			community designated as an		
	• •	o leave the facility with			"independent living area", as	(in	
	_	nber for an outing. She			indicated in the survey finding italics added by the surveyor,	(111	
		iit exit door, and			page 6 of 19). While some		
	•	eone (staff) to assist			residents who reside on the		
	her in opening	the exit door (because			Terrace, (as well as other area	as	
	it required a co	de to be entered on			of the Assisted Living		
	the key pad).	On 4/30/13 at 10:00			Community) may be	al Ia	
	A.M., the resid	ent was observed			wheelchair-bound, as indicated the survey findings, additional	и бу	
	standing at the	Nurse's Station on the			escort help is available to thos	е	
	unit. She had	a notebook and pen,			who request and/or require this		
		g the nurse about			service, and is addressed on t	heir	
		the facility had a			personal service plans. The		
		I, and if she was taking			Terrace area of the community		
	J .	ns. After asking and			now has the code posted at the		
		wer, she would ask			door to allow entrance and egree from the Terrace area into the	<del>6</del> 88	
		s, and then come back			remainder of the community, to	0	
					allow intra-community movement		
	-	lestions, again asking			at the discretion of the residen		
	•	nd vitamins. She			· Personal Service Assessme		
		writing the information			and Personal Service Plans fo	r all	
		tebook, but would			Terrace residents have been	,	
	repeat the sam	ne questions several			updated by a licensed nurse to	,	

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 6 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			04/30/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RAIG ST		
DEDVEL	IRE OF CASTLETO	ON.			APOLIS, IN 46250		
DERNOI	INE OF CASTLETO	311		INDIAN	AFOLIS, IN 40250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	times.				include documentation of their		
					specific needs that are able to	be	
	C. The clinical record for Resident				better met by residing on the		
	#10 was reviev	wed on 4/30/13 at 9:15			Terrace area of the AL. Physician orders were obtaine	d to	
		dent was originally			reflect their appropriateness to		
		e "independent" area of			reside on the Terrace area of t		
		•			community. What measures w		
	,	2/22/10. Diagnoses			be put in place or what system		
		vas not limited to,			changes will the facility make t		
	,	disease, diabetes,			ensure the alleged deficient		
	history of urina	ry tract infections, and			practice does not recur?		
	cystocele.				Residents will continue to be		
					assessed by the licensed prior	to	
	A nurse's note	, dated 1/14/13,			move-in, within 14-30 days of move-in, every 6 months, and		
		ident attempting to			with condition change, as per		
		" A note dated 2/11/13			existing policy. • At the time of	of	
		to [family member] to			each assessment, the resident		
					designated responsible parties		
	l discuss possib	le move to Terrace"			and physician will be notified if	:	
					there is a potential resident ca	re	
		as moved to the locked			need which could be better	_	
	unit on 2/22/13	3.			addressed on the Terrace area		
					the community. · A Collabora		
	A physician's o	order for the move to			Care meeting will take place to monthly with members of the	vice	
	the locked unit	was not found. The			interdisciplinary team to review	v	
	April, 2013 phy	sician order recap			residents for changes in	-	
	(recapitulation)	•			condition, which may warrant a	a	
		ddition of "Change			change to the Personal Servic		
		o [her current room			Plan, which would include a		
		-			resident transfer. In the even		
	number on Ter	race was listed]."			transfer is necessary from one		
	<u></u>				area of the community to anoth		
	A Service Plan				distinct area of the AL communitransfer orders will be obtained	•	
	included " D	oes not require			from the physician and resider		
	bathroom assis	stance; Independent			and/or responsible party will be		
	going to and fr	om dining room or			informed of the findings and th		
	community act	_			need for a change to the Perso		
					Service Plan. The licensed		

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 7 of 30

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/30/2013
	PROVIDER OR SUPPLIEF		8480 C	ADDRESS, CITY, STATE, ZIP CODE RAIG ST IAPOLIS, IN 46250	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE
	Service Plan we required to live D. The clinical #16 was review P.M. The resid admitted to the facility on 8 included, but we rheumatoid arthearing loss, me dysphagia, lum spasms, and searchearing loss, me dysphagia, lum spasms, and searchearing loss, me dysphagia, lum spasms, and searchearing loss, me dysphagia, lum spasms, and searchear Programmer's ty A Dietary Programmer's ty Dietary Pro	ress note, dated ated "Admit from ependent living area] to with Hospice order for the move to a s not found.		nurse will be responsible for completion of the appropriat transfer paperwork for intra-community transfers at any necessary notifications. will the corrective actions be monitored to ensure the def practice will not recur, i.e., w quality assurance programs be put into place? The Executive Director, and other members of the interdisciplinate and ongoing manner to review residents for changes in corrand to determine the most appropriate interventions to Personal Service Plan to me the needs of the individual resident.	nd How exicient yhat will er nary ly in w adition

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 8 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
			B. WIN			04/30/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			RAIG ST		
BEBKSH	IRE OF CASTLETO	N			APOLIS, IN 46250		
DLINIOII				INDIAN	Al OLIO, IIV 40230		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		1:10 P.M., the resident					
		sitting in a wheelchair					
	in the dining room following the lunch						
	meal. A staff person came and						
	propelled her in	n her wheelchair back					
	to her room, ar	nd assisted her to					
	transfer to sit in						
	F The clinical	record for Resident					
		ved on 4/29/13 at 2:00					
		dent was originally					
		e "independent" area of					
		5/4/12. Diagnoses					
		vere not limited to,					
		aAlzheimer's type,					
	diabetes, dysp	hagia, glaucoma, and					
	hearing loss.						
	A nurse's note	, dated 11/2/12					
	indicated "This	writer observed					
	resident elopin	g without his walker					
		airs by his room. He					
		by writer" A note					
		indicated "Spoke with					
		•					
		ntative] regarding					
	•	to Terrace due to					
		se in confusion and					
	wandering."						
	A note dated 1	1/6/12 indicated					
	"Transferred to	[the apartment					
		race was listed]"					
		•					
	A physician's c	order for the move to a					
	locked unit was						
	I Joured Will Was	a not lound.					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/30/2013
NAME OF F	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP CODE	
				RAIG ST	
BERKSH	IRE OF CASTLETO	ON	INDIAN	IAPOLIS, IN 46250	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	was observed walker from his room and back room was loca hall and next to outside. A key for exit was local	/30/13, the resident ambulating with a serios room to the dining a several times. His set at the end of one or an exit door to the property pad to enter a code cated on the wall next to			
	the door.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED				
			B. WING		04/30/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8480 CRAIG ST INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION			
R000091	a written policy mesident care and attained, to include (1) The range of (2) Residents' rig (3) Personnel address shall residents upon residents.  Findings include Terrace unit.  Findings include Terrace unit was requiring a code pad at all entraindicated the unit as an Alzheime Care unit.  In an interview orientation tour	all establish and implement annual to ensure that a facility objectives are de the following: services offered. hts. ministration. tions. I be made available to equest. Eview and record ality failed to establish a written policy and ated to admittance to race unit. This the potential to impact ents living on the	R000091	Addendum to R 91: The polithe POC does not reflect crit for a resident who is unable utilize the keypad system. Is there a policy or plan for tho residents? Response: No additional poor plan will be required becared is no longer required to the rest of the community Personal Service Assessme currently in use will continue utilized prior to move-in, upon move-in, within 14-30 days a move-in, every 6 months and with a condition change. R_091 Administration and ManagementWhat corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice? The community has an establish written policy manual to ensithat resident care and facility objectives are attained, as required by Indiana regulation. Assisted Living Policy and	teria to s se plicy puse a p exit . The ent e to be pn after d/or e ed for ve d ure y ons.			

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 11 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLE	TED
				LDING		04/30/2	.013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEDIKOL	UDE OF OAOT! ET	2.1			RAIG ST		
BERKSH	IIRE OF CASTLETO	JN		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Director indica	ted 7 of the 21			Procedure Manual" contains the	ne	
	residents residing on the Terrace unit				"Admission/Discharge criteria		
		airs for mobility. The			Policy" for Indiana and contain		
		ents were ambulatory.			criteria utilized to admit and re		
		3 of the residents could			older adults. · As the Terrace		
					area of the community now hat the code posted, the existing A		
		, but each had some			Admission Criteria currently	\L	
	level of forgetf	ulness or confusion.			indicates those residents who		
					may be admitted and retained	in	
	In an interview	on 4/30/13 at 10:15			the AL community. · Any		
	A.M., the Adm	inistrator indicated			transfer to The Terrace would	be	
	residents were	moved to the Terrace			discussed with all parties		
		level of needs			involved, including the physicial		
		l a change in condition			responsible party, and residen	t as	
		ner level of assistance			indicated, prior to changing		
					resident's location, unless the		
		ndicated the "biggest"			resident no longer meets admissions criteria. • The		
	_	sually one of developing			community reserves the right t	ro l	
	or increasing in	ncontinence or			staff some areas of the Assiste		
	transferring (in	and out of bed, in and			Living community at higher lev		
	out of a wheel	chair). The Terrace			than others, based on acuity,		
	unit had a high	er staffing ratio to be			resident preferences and resident	lent	
	_	this assistance.			needs. · Per our existing poli-	cy,	
					the community may admit and		
	In the interview	v, the Administrator			retain a resident who:A). Can		
					exhibit signs of confusion and		
		e was no reason the			forgetfulness, and behaviors of be managed through	an	
		locked"It's always			programmatic servicesB). Can	,	
		As far as she was			exhibit wandering behavior; but		
	aware, the unit	t had never been			elopement is a risk, behavior		
	designated an	Alzheimer's/Special			must be able to be managed		
	Dementia Care	e unit.			through programmatic		
					servicesC). Has a personal		
	In an interview	on 4/30/13 at 11:15			Physician willing to provide		
		inistrator indicated she			on-going medical supervision[		
	· ·				Does not require 24 hour skille		
	1	ought about the unit			nursing services for an extend		
	_	pecause it had been			period of timeE). Does not req	uire	
	that way since	she was first employed			24 hour continuous skilled		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		04/30	)/2013
NAMEOUR	DOMDED OF GURDINE		STREET .	ADDRESS, CITY, STATE, ZIP COL	DE .	
NAME OF F	PROVIDER OR SUPPLIEF	C .	8480 C	RAIG ST		
BERKSH	IRE OF CASTLETO	ON	INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		OTT O. V	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	JLD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
	Administrator pexcerpt from the	11:30 A.M., the provided a copy of an he facility's admission ighlighted the part she		require 24 hour compret nursing care or oversigh experiencing behavior th be dangerous to self and othersH). Must be considered in medically stablel). Does	tG).Is not lat would I dered not	
	felt addressed	the issue. The		require restraintsJ). Mus capable of payment for s		
		luded, but was not		in accordance with the R		
	limited to, the following:			AgreementK). Must be fi	ee from	
"C. RIGHT OF ENTRY We reserve				communicable diseases will the facility identify ot		
	the right to relocate appropriate Succeeding	cate you to a more lite within the required for your y, or because the companion Suite are ."  ator indicated the specific policy or ressing the locked unit s/criteria needed to		residents with the potent affected by the same alled deficient practice and who corrective action will be a The community has an established written policito ensure that resident of facility objectives are attactive attactive and the action of the content of th	eged nat raken? y manual are and ained. iving nd ains the iteria ontains and retain	
	move to triat di			older adults. · As the To area of the community in the code posted, the exist Admission Criteria curre indicates those residents may be admitted and ret the AL community. · Ar transfer to The Terrace in discussed with all parties involved, including the presponsible party, and resident's location, unless resident no longer meets admissions criteria. · The community of the control of the community of the control of the community of the control of the co	ow has sting AL ntly s who ained in ly would be s hysician, esident as ing ss the	

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 13 of 30

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING  B. WING		COMPLETED 04/30/2013	
NAME OF P	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
	IRE OF CASTLETC			RAIG ST IAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				community reserves the right of staff some areas of the Assisted Living community at higher lever than others, based on acuity, resident preferences and need. Per our existing policy, the community may admit and reta a resident to any area of the assisted living who:A). Can exhibit signs of confusion and forgetfulness, and behaviors of the bemanaged through programmatic servicesB). Can exhibit wandering behavior; but elopement is a risk, behavior must be able to be managed through programmatic servicesC). Has a personal Physician willing to provide on-going medical supervision Does not require 24 hour skilled nursing services for an extend period of timeE). Does not require 24 hour continuous skilled nursing servicesF). Does not require 24 hour comprehensive nursing care or oversightG). Is experiencing behavior that wo be dangerous to self and othersH). Must be considered medically stablel). Does not require restraintsJ). Must be capable of payment for services in accordance with the Reside AgreementK). Must be free from the communicable diseases. What measures will be put in place of what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Nursing staff will be reducated on the location of the control	ed vels ds. ds. ain  D). ed led luire e not luid es, ency om lat or lee lee lee lee lee lee lee lee lee le	

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 14 of 30

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00 	COMPI 04/30				
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER	L	8480 CRAIG ST					
BERKSH	IRE OF CASTLETO	DN	INDIAN	IAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
				Assisted Living Policy and Procedure Manual, in the eresident or family member requests information regar written policy. The Assist Living Policy and Procedur Manual is also available or and, in the event requester specific policy may be prin reference. The specific "Admission/Discharge Critic policy as well as the "Clinic Guidelines for Admission For Criteria" will be available a nurse's station for ease of reference. How will the corrections be monitored to enthe deficient practice will not recur, i.e., what quality assignorgrams will be put into porthe Executive Director/He and Wellness Director/Deswill review any move-in assessment and/or transfer request which indicates the potential need for change is resident location-either with community or to a different setting, in order to determinal appropriate action necessarial.	event a  ding a ed ee en-line d, a ted for eria" cal Review t each rective sure ot urance lace? alth ignee r en in the care ne the			

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 15 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
			B. WING		04/30/2013	
	n o v v n n n o			ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIEF	₹		RAIG ST		
	IRE OF CASTLETO		INDIANAPOLIS, IN 46250			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R000214	410 IAC 16.2-5-2 Evaluation - Defice	• •				
		of the individual needs of				
	each resident shall be initiated prior to					
		nall be updated at least				
		d upon a known substantial				
	change in the res	sident 's condition, or more				
	often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record					
			R000214	Berkshire of Castleton addeng	dum 05/29/2013	
		ility failed to evaluate	1000214	responses for annual survey:	03/27/2013	
	the individual r	•		4-30-13		
		wed, who were moved		Addendum request R 241:	Can	
	-	endent living area of		all residents residing on the		
	•	ne locked Terrace unit.		Terrace Unit utilize the keypad		
	(Residents #6,	#7, #10, #16, and #21)		with the appropriate code to e the unit? Response: Because		
				not all residents living on the		
	Findings include	le:		Terrace area are able to mana	age	
				a keypad for exit, we have		
	In an interview	during the entrance		decided to unlock the door,		
	conference on	4/29/13 at 9:45 A.M.,		allowing access to the remain	der	
	the Administra	tor indicated the		of the community.		
	Terrace unit wa	as a locked unit,		Addendum to R241: How wer	re l	
	requiring a cod	le be entered into a key		all the residents assessed to		
		nces and exits. She		ensure they could exit the unit	: at	
	•	nit was not designated		will by the use of the keypad?		
		er's/Special Dementia		Response: The Personal Ser		
	Care unit.			Assessment will be utilized for		
	Jaio unit.			residents in the community, a	S IT	
	In an interview	during the initial		addresses all physical and cognitive issues related to		
		during the initial		resident care and services.		
		r on 4/29/13 at 10:00		Because the unit will no longe	r be	
	·	th and Wellness		locked, no additional assessm		
	Director indicated 7 of the 21			will be required.		
	residents resid	ing on the Terrace unit				
	used wheelcha	airs for mobility. The		Addendum to R241: For		
	other 14 reside	ents were ambulatory.		residents residing on the Terra	ace	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	ETED
			B. WING			04/30/2	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			RAIG ST		
DEDKEH	IRE OF CASTLETO	DNI.			APOLIS, IN 46250		
DERNON	IRE OF CASTLETO	JN		INDIAN	APOLIS, IN 40250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	She indicated 3	3 of the residents could			unit who cannot utilize the	]	
	be interviewed	, but each had some			keypad, have they been asses	ssed	
		ulness or confusion.			for a locked unit with appropria		
	l level of lorgetit	diffess of confusion.			physician orders, assessment		
					and service plans to reflect thi	s?	
	In an interview	on 4/30/13 at 10:15			Response: No additional		
	A.M., the Admi	nistrator indicated			assessment for a locked unit v	vill	
	residents were	moved to the Terrace			be required, because the		
	unit when their	level of needs			residents now have access to		
		a change in condition			other areas of the community		
	· ·	•			without having to utilize a code Physician orders will be obtain		
	required a higher level of assistance by staff. She indicated the "biggest"				for transferring residents to the		
					Terrace, as a higher level of c		
	change was us	sually one of developing			needs can be met in the small		
	or increasing ir	ncontinence or			environment.		
	transferring (in	and out of bed, in and			GIVII GIIII GIII.		
	l • ;	chair). The Terrace			Addendum to R241: How often	n I	
		er staffing ratio to be			will the residents on The Terra		
					unit be evaluated on the ability	/ to	
	able to provide	this assistance.			utilize the keypad and exit the	unit	
					at will?		
	In the interview	, the Administrator			Response: No additional		
	indicated there	was no reason the			assessment for a locked unit v	vill	
	unit had to be I	ocked"It's always			be required, because the		
		As far as she was			residents now have access to		
		had never been			other areas of the community		
		Alzheimer's/Special			without having to utilize a code	<del>)</del> .	
	•	•			R _214 EvaluationWhat		
	Dementia Care	unit.			corrective action(s) will be accomplished for those reside	nts	
					found to have been affected b		
	In an interview	on 4/30/13 at 11:15			the alleged deficient practice?		
	A.M., the Admi	nistrator indicated she			Residents #6, #7, #10, #16, ar		
	hadn't really the	ought about the unit			#21: The Terrace area of the		
		•			community now has the code		
	being locked, because it had been that way since she was first employed				posted at the door to allow		
	1	one was mot employed			entrance and egress from the		
	at the facility.				Terrace area into the remaind	er	
					of the community, to allow		
	The clinical rec	cords for 5 of the			intra-community movement at	the	
	residents living	on the unit indicated			discretion of the resident.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
			B. WING			04/30/	2013
			<del>'</del>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RAIG ST		
BERKSH	IRE OF CASTLETO	NC			APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the following:				Residents #6, #7, #10, #16 an	d	
					#21: Personal Service		
	A. The clinical record for Resident #6				Assessments and Personal		
		on 4/29/13 at 10:50			Service Plans have been upda	ited	
					by a licensed nurse to include		
		dent was originally			documentation and data correction information regardir	na	
		e "independent" area of			the need for these individuals	-	
	1	I/19/09. Diagnoses			reside on the Terrace, based of		
	· ·	vere not limited to,			the care needs identified on th		
	dementia, Parl	kinson's disease,			assessment. Residents #6, #		
	depression, an	d benign prostatic			#10, #16, and #21: Physician		
	hypertrophy (enlarged prostate).				orders were obtained to reflect	_	
		,			their appropriateness to reside	on	
	The weight log	documentation			the Terrace area of the		
		esident had been in his			community. How will the facility		
					identify other residents with the potential to be affected by the	Э	
		errace unit since at			same alleged deficient practice	<u>م</u>	
	least 4/18/12.				and what corrective action will		
					taken? Other residents with t		
		was not found related			potential to be affected by the		
	to the specific	needs that required the			alleged deficient practice		
	resident to live	in a locked unit.			currently reside on the Terrace	e. ·	
					The Terrace area of the		
	B. The clinical	record for Resident #7			community is, by plan, an area		
		on 4/30/13 at 8:30 A.M.			where the staffing ratio is high	er	
		nd a family member			than the rest of the AL community, and where there is	2 2	
		•			designated licensed nurse	оа	
		to the same apartment			present to provide med		
		ident" area of the			administration communicate w	rith	
		8/13. Diagnoses			the physician on behalf of the		
	· ·	vere not limited to,			resident, certified nursing		
	depression and	d senile dementia-			assistants present to supervise	Э	
	-Alzheimer's ty	rpe.			and assist with ADL care and		
					dining needs, as well as		
	A nurse's note	. dated 3/9/13.			Optimum Life Programming	ot	
		esident was alert and			available, in order to better me the physical and cognitive nee		
		e, place, and person.			of residents who may not func		
		c, place, and person.			as highly in the larger population		
					and the second s		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
			B. WING			04/30/	2013
		<u> </u>	B. WIIK		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			RAIG ST		
REDKSH	IRE OF CASTLETO	∩N.			APOLIS, IN 46250		
DLIMOII	INC OF CASTLLIN	JIV		INDIAN	AI OLIO, IN 40250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	In an interview on 4/30/13 at 10:00				of this AL community. • This	23	
	A.M., LPN #1 indicated the resident				apartment area is available to		
	had been mov	ed to the locked unit on			allow a higher level of success		
	3/28/13.				residents who desire to remain the assisted living community		
	6/26/16.				their choice and preference, a		
	Δn evaluation	was not found related			is not designed to restrain or		
					restrict their ability to visit and		
	· ·	needs that required the			participate in activities in any		
	resident to live	in a locked unit.			other area of the community.		
					Note: The entire community is		
	C. The clinical record for Resident				licensed as an Assisted Living		
	#10 was reviev	wed on 4/30/13 at 9:15			community, consisting of 139		
	A.M. The resid	dent was originally			apartments (23 of these licens	ea	
	admitted to the	e "independent" area of			AL apartments are on The Terrace), and with a capacity t		
		2/22/10. Diagnoses			provided residence to up to 17		
		vas not limited to,			individuals. There is no area		
	•	: disease, diabetes,			this community designated as		
					"independent", as indicated in	the	
		ary tract infections, and			survey finding. While some		
	cystocele.				residents who reside on the		
					Terrace, (as well as other area	as	
	A nurse's note	, dated 1/14/13,			of the Assisted Living		
	indicated "Res	ident attempting to			Community) may be	al Ia	
	cook on stove.	" A note dated 2/11/13			wheelchair-bound, as indicate the survey findings, additional	а бу	
	indicated "Call	to [family member] to			escort help is available to thos	۵	
		ole move to Terrace"			who request and/or require thi		
					service, and is addressed on t		
	The resident w	vas moved to the locked			personal service plans. The		
					Terrace area of the community	/	
	unit on 2/22/13	).			now has the code posted at th		
					door to allow entrance and eg		
		was not found related			from the Terrace area into the		
	to the specific	needs that required the			remainder of the community, to		
	resident to live	in a locked unit.			allow intra-community movement		
					at the discretion of the residen  Personal Service Assessme	-	
	D. The clinical	I record for Resident			and Personal Service Plans fo		
		wed on 4/29/13 at 1:20			Terrace residents have been		
					updated by a licensed nurse to		
		dent was originally				-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		04/30/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			RAIG ST		
DEDKOL	IRE OF CASTLETO	) NI		IAPOLIS, IN 46250		
	INE OF CASILEIC	л	INDIAN			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	admitted to the	"independent" area of		include documentation of their	•	
	the facility on 8	3/27/11. Diagnoses		specific needs that are able to	be	
	•	vere not limited to,		better met by residing on the		
		hritis, osteoporosis,		Terrace area of the AL.	1.6	
		•		Physician orders were obtained		
	_	nacular degeneration,		reflect their appropriateness to reside on the Terrace area of		
		nbar scoliosis, bladder		community. What measures v		
	•	enile dementia-		be put in place or what system		
	-Alzheimer's ty	pe.		changes will the facility make		
				ensure the alleged deficient		
	A Dietary Prog	ress note, dated		practice does not recur?		
		ated "Admit from		Residents will continue to be		
	· ·	ependent living area] to		assessed by the licensed prior	r to	
	-			move-in, within 14-30 days of		
	Terrace 8/7/12	with Hospice		move-in, every 6 months, and		
	services."			with condition change, as per		
				existing policy. At the time of		
	An evaluation \	was not found related		each assessment, the residen	1	
	to the specific i	needs that required the		designated responsible parties		
		in a locked unit.		and physician will be notified in		
				there is a potential resident ca need which could be better	iie	
	E The clinical	record for Resident		addressed on the Terrace are	a of	
				the community. • A Collabora		
		ved on 4/29/13 at 2:00		Care meeting will take place to		
		dent was originally		monthly with members of the		
	admitted to the	"independent" area of		interdisciplinary team to review	v	
	the facility on 5	5/4/12. Diagnoses		residents for changes in		
	included, but w	ere not limited to,		condition, which may warrant		
	,	aAlzheimer's type,		change to the Personal Service	e	
		hagia, glaucoma, and		Plan, which would include a		
	hearing loss.	riagia, giadooriia, aria		resident transfer. In the even		
	nearing 1055.			transfer is necessary from one		
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		area of the community to anot		
	A nurse's note,			distinct area of the AL commu transfer orders will be obtained	-	
	indicated "This writer observed resident eloping without his walker			from the physician and resider		
				and/or responsible party will b		
	going down sta	airs by his room. He		informed of the findings and th		
	0 0	by writer" A note		need for a change to the Pers		
		indicated "Spoke with		Service Plan. The licensed		
	ualeu 11/2/12 1	indicated opone with				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00			COMPLETED	
			B. WING			04/30/	2013	
		<u> </u>	1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				RAIG ST			
	IRE OF CASTLETO			INDIAN	APOLIS, IN 46250			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE	
		tative] regarding			nurse will be responsible for completion of the appropriate			
	•	to Terrace due to			transfer paperwork for			
	resident increa	se in confusion and			intra-community transfers and			
	wandering."				any necessary notifications.Ho			
					will the corrective actions be			
	A note dated 1	1/6/12 indicated			monitored to ensure the defici	-		
	"Transferred to	[the apartment			practice will not recur, i.e., who			
		race was listed]."			quality assurance programs w be put into place? The	111		
		-			Executive Director, and other			
	An evaluation v	was not found related			members of the interdisciplina	ry		
		needs that required the			team, will meet twice monthly	-		
		in a locked unit.			an ongoing manner to review			
		in a looked and.			residents for changes in condi	tion		
	During the daily	y conference on			and to determine the most	_		
	4/30/13 at 10:1				appropriate interventions to the Personal Service Plan to meet			
		·			the needs of the individual			
	Administrator a				resident.			
		tor were given the						
	opportunity to s	_						
	documentation							
		ne specific needs of						
	Residents #6, 7	#7, #10, #16, and #21						
	to be moved to	a locked unit.						
	In an interview	on 4/30/13 at 1:00						
	P.M., the Healt	h and Wellness						
	Director indicat	ed there would not be						
	any specific inf	ormation related to the						
		cked unit because the						
		previously considered						
	_	ey were more focused						
		<del>-</del>						
	on the unit as being one to provide a higher level of assistance within the							
	·	a Residential-licensed						
	unit.							

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			A. BUILDING B. WING		04/30/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		RAIG ST		
BEDRON	IIRE OF CASTLET	ON		RAIG ST IAPOLIS, IN 46250		
				MAF OLIO, IIN 40200		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		IATE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	I .		1	I		

State Form Event ID: HZ8211 Facility ID: 009894 If continuation sheet Page 22 of 30

		IDENTIFICATION NUMBER:	A. BUIL B. WIN	DING	00	COMPLETED 04/30/2013	
	ROVIDER OR SUPPLIER			8480 CF	ADDRESS, CITY, STATE, ZIP CODE RAIG ST APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
R000217	the facility, using members, shall id services to be profollows:  (1) The services of resident shall be at (A) scope;  (B) frequency;  (C) need; and  (D) preference; of the resident.  (2) The services of and revised as appeared to the resident and for change. Either the may request a second and dated copy of the services provided subsequent to the no need for a change. It is not to the notion of the services provided subsequent to the notion of resident upon request of the services provided subsequent to the notion of the services to be assed on recording the services to be as the services to be a	pletion of an evaluation, appropriately trained staff entify and document the wided by the facility, as offered to the individual appropriate to the:  offered shall be reviewed appropriate and discussed by acility as needs or desires a facility or the resident revice plan review. Soon service plan shall be by the resident, and a se plan shall be given to the uest. On and documentation of is needed if evaluations a initial evaluation indicate nge in services, or an of medications or the cential nursing services, or a licensed nurse shall be ication and documentation be provided.	R00	0217	R _217 Evaluation What corrective action(s) will be accomplished for those resider found to have been affected by the alleged deficient practice? ·Resident 102: Personal Service Plan has been updated by the Health and Wellness Director to include the interventions currently in place	nts / d	05/29/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
					<del></del>	04/30/	2013
			B. WIN		ADDRESS OVEN STATE OF CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEDICOL	UDE OF OAOT! ET	2.1			RAIG ST		
BERKSH	IIRE OF CASTLETO	JN		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	de:			address resident's symptoms	of	
					anxiety and depression. Thes	е	
	1 Record revie	ew for resident # 102			interventions include Life		
	was completed on 4/30/13 at 1:10				Enrichment Programming and		
	p.m. Diagnoses included, but were				utilization of the Optimal Life		
					Evaluation form to develop resident-specific interventions		
		diabetes type II,			and on-going monitoring		
	•	and depression with			recommendations by the		
	psychotic featu	ıres.			physician.		
					Resident 107: Resident's		
	The resident also had two admissions				Self-administration of Medicati	ons	
	into a stress center related to her				Evaluation has been updated	to	
	depression. The admission note				reflect resident's inability to		
		indicated, "referred			continue to self-administer		
					medications. The Personal		
		from her assisted living			Service Plan has been update		
		ncreasing withdrawal			include nursing's provision of radministration.	nea	
	1	The patient appeared					
	increasingly de	epressed and not			How will the facility identify oth	er	
	leaving her apa	artment and was not			residents with the potential to		
	coming out for	mealsafter the			affected by the same alleged		
	reduction of CI	onazepam, she noted			deficient practice and what		
		rovement in alertness			corrective action will be taken?	?	
		d insomnia appeared			· Residents who		
	_	• •			self-administer medications wi		
	to remain well	•			be reviewed by the Health and		
		n her assisted living			Wellness Director/Designee to		
	· ·	ecommended that the			ensure the current evaluation in the clinical record is accurate.	ın	
	patient would r	need an increased level			The Collaborative Care		
	of support rela	ted to her cognitive			meeting and Morning meeting	will	
	decline"				be utilized as a tool to docume		
					discussion regarding resident's		
	The nurses no	tes for 3/1/13 at 9:50			continued medication safety a		
					ability, based on observations		
	a.m. indicated, "Resident had choking episode in MDR [main dining room]				the team.		
					In the event a resident is		
		1 Resident stated she			longer evaluated as able to sa	fely	
		orange juicenoted			self-administer medications, a		
	audible 'girgle'	[sic] sound on			care conference will occur with	ו	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
		B. WIN			04/30/2	2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					RAIG ST		
BEDKSL	IIRE OF CASTLETO	N			APOLIS, IN 46250		
DERNOI	IINE OF CASTLETO	5N		INDIAN	AFOLIS, IN 40250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
	inspiration [sig	n for and] expiration"			resident and responsible party		
				involvement to discuss the need for change.		ed	
	A physician vis	sit note dated 3/8/13					
		lan: Dysphagia-Has			The Personal Service Plan will then be updated as soon as the responsible party can be notified of the change in Personal Service fees related to such a change.		
		ng episodes on 3/1 and					
		d of which requiring ER					
		om] visit and removal					
		eal foreign body. Pt.			Nurses will be re-educate	ed	
	1	d on soft mechanical			by the Health and Wellness		
	diet. Needs S	peech Therapy			Nurse on completion of the		
	evaluation"				Self-administration evaluation		
	The service plan in the chart was dated 10/7/12 and indicated for nutrition, "Meal portion: Regular No				form and notification		
					requirements for making a		
					change in the Personal Service Plan.	e	
					Plan.		
					What measures will be put in		
	known food allergies. Comments Able				place or what systemic change	es	
		carb intake" The			will the facility make to ensure		
	service plan wa	as not updated to			alleged deficient practice does		
	include potenti	al for choking or her			not recur?		
	new mechanic	al soft diet. The			<ul> <li>The Health and Wellness</li> </ul>		
	service plan al	so indicated, "Resident			Director/Designee will receive		
	•	hotic or benzodiazepine			copy of order changes, in orde		
		Be alert for expressions			complete updates to the Perso		
		in behaviors. Be alert			Service Plan on a timely basis		
	· ·				Those changes which do not affect pricing, may be		
		due to antipsychotic or			hand-written on the existing		
	•	e medications. Be			Personal Service Plans and/or		
	alert to dry mouth. Conduct periodic review of psychotropic medications.  Be alert to changes in appetite, Be alert to medication related fall risk due to antipsychotic or benzodiazepine				Care Profiles currently in use a		
					the community.		
					How will the corrective actions		
					monitored to ensure the deficient		
	medications	· · · · · · · · · · · · · · · · · · ·			practice will not recur, i.e., wha		
		Chronic Conditions may			quality assurance programs wi	III	
		_			be put into place?	_	
		ent's activities of daily			The Health and Wellness		
	living. Refer to other sections of the				Director/Designee will keep an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED		
		B. WING		04/30/2013		
		1	_	Γ ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIEF	8		CRAIG ST		
BERKSHIRE OF CASTLETON				NAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	service plan fo	r further		updated list of all residents w	no	
	directionForce	getful and confused		self-administer medications.		
	from time to tin			The Self-Administration form will be updated by a nurse		
	The service no	an indicated no support		upon move-in, every 6 month and with significant condition	8	
	·	esident received for		change ongoing.		
				· Any changes required,		
	her depression	i anu anxiety.		based on new or updated evaluations, will be		
	2. Record revie	ew for Resident #107		communicated to the Health	and	
	was completed	l on 4/29/13 at 1 p.m.		Wellness Director/Designee i		
	•	uded, but were not		order to have the Personal		
	limited to, lymphoma, depression, renal insufficiency, diabetes type II and high blood pressure.			Service Plan updated.		
	The service pla	an for Resident #107				
	•	indicated, "Resident				
		heir medications				
	_	administering, ordering,				
	_	nd safe storage"				
	coordinating at	iu sale storage				
	In an interview with the Health and Wellness Director on 4/29/13 at 10:30					
	a.m., she indic	ated she was unsure of				
		tus of Resident #107				
	regarding if staff gives medications or					
if he takes them independently. She also provided a list of residents that						
	•					
		able and Resident				
	#107 was on the list.  The clinical record under					
	assessments in	ncluded a document				
	titled, "Self-Adr	ministration of				
	·	eview" dated 1/29/13.				
		CVICVV dated 1/20/10.				

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		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
			B. WING		04/30/2013
NAME OF P	DOVIDED OD GUDDI IED		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	•	8480 C	RAIG ST	
	IRE OF CASTLETO			APOLIS, IN 46250	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		nt indicated the			
		apable of taking his			
	own medication	ns.			
	The Mark Control	- A desirate to 4			
		n Administration			
		oruary 2013 indicated			
	the staff had be	-			
	medications to	Resident #107.			
		W D 11 / W 2			
		with Resident #107 on			
		5 a.m., the resident			
		d not know what his			
	medications were, what they were for				
	and that he cannot currently do his medications on his own and needs staff to help give him his medicaitons.  In an interview with the Health and Wellness Director on 4/30/13 at 2				
	-	ated they would			
		e a service plan to			
	_	es like that of Resident			
#102 and Resident		·			
	residents were				
	semi-annual and she was currently working on them. She also indicated the staff had been assisting Resident				
		e now due to his			
	confusion with when to take pain				
	medications.				
					ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED				
			A. BUILDING B. WING		04/30/2013			
NAME OF PROVIDER OR SUPPLIER BERKSHIRE OF CASTLETON			STREET ADDRESS, CITY, STATE, ZIP CODE  8480 CRAIG ST INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
R000349	on each resident. maintained under employee of the fresponsibility. The follows: (1) Complete. (2) Accurately do (3) Readily access (4) Systematically Based on reco- interview, the fresidents review documentation  Findings include  Record review completed on a Diagnoses including include  Resident #136 hospital on 1/2 died at the hose  A document title or Discharge is neighbor to the indicated, "Title discharge is neighbor to the maintained under maintained maintained under maintai	- Noncompliance ust maintain clinical records . These records must be r the supervision of an facility designated with that e records must be as  cumented. ssible. y organized. rd review and acility failed to have entation related to the sident for 1 of 2 wed for transfer . (Resident #136)  le:  for Resident #136 was 4/29/13 at 11 a.m. uded, but were not ression, macular and congestive heart  was discharged to the 9/13 and the resident pital.  led "Notice of Transfer was dated 5/12/12 and	R000349	R_349 Clinical Records What corrective action(s) will accomplished for those reside found to have been affected be the alleged deficient practice? Res #136: The clinical rec for this resident was amende the Health and Wellness Dire to include the proper transfer date. The discharge summar the closed record was amend by the Health and Wellness Director to include the approp disposition location for the resident. The amended reco will be co-signed by the Exec Director. How will the facility identify of residents with the potential to affected by the same alleged deficient practice and what corrective action will be taken Transfer and Discharge records for the past 30 days or reviewed for compliance by th Health and Wellness Director Designee. Nurses responsible for resi transfers and discharge documentation were provided	ents by ? cord d by cctor  y for led  priate  rd  utive  ther be  n?  were  ne -/			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		B. WING			04/30/2013		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
BERKSHIRE OF CASTLETON					RAIG ST		
DEKNON	IIRE OF CASTLETO	N		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	needs cannot l	be met at the facility"			re-education by the Health and	t	
		,			Wellness Director/Designee or	ı	
	Another docum	nent with the facility		the proper procedure for copy		ng	
		-			of the emergency packet and		
	corporation na				transfer documentation		
		nsfer/Discharge" also			requirements.		
	dated 5/12/12,	indicated, "Resident			What measures will be put in		
	sent out due to	change in mental			place or what systemic change will the facility make to ensure		
	status"				alleged deficient practice does		
					not recur?	•	
	A document tit	led, "Discharge			·All clinical records were		
		ed 1/29/13, indicated			updated to include blank		
	,	-			emergency transfer forms.		
	the resident's move out date was 1/29/13. The summary indicated, "the resident was discharged to a funeral home and the discharge was due to death, list cause if known:				·Emergency packets are		
					available for copying prior to a	ny	
					transfer.	-	
					·Additional blank forms were		
					made available to all shifts at		
	•	toma" The form			each wellness center and a nu		
		d dated 2/3/13 by the			designee will be responsible for	or	
	_	th and Wellness			auditing the supply of forms		
		ui and weimess			weekly.  How will the corrective actions	ho	
	Director.				monitored to ensure the deficie		
					practice will not recur, i.e., wha		
	In an interview	with the Health and			quality assurance programs wi		
	Wellness Director on 4/29/13 at 3				be put into place?		
	p.m., she indic	cated the resident had			The Health and Wellness		
	been sent out several times in the last				Director / Assistant Health and		
					Wellness Director/Designee w	ill	
	few months due to her age and complications. She believed due to the urgency in getting the resident to the hospital, the nurse may have copied an old transfer form due to not having access to one. She indicated whoever completed documentation for Resident #102's record did not				be responsible for reviewing th	ne	
					clinical record of all transfers a		
					discharges within 48 hours of t		
					event to audit for compliance v		
					dates and location/disposition	of	
					resident.		
					·The Health and Wellness		
					Director/Assistant Health and Wellness Director /Designees	will	
	catch the error				be solely responsible for	vv 111	
					completion of the Discharge		
			1		Sompletion of the Disonarge		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BERKSHIRE OF CASTLETON			8480 CRAIG ST INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
				CROSS-REFERENCED TO THE DEFICIENCY)  Summery for the close The Executive Directory audit results and further recommendation any issues identifies subsequent audits.	ed record. ctor will nd will make ons based			

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